SSI Managed Care Quality Assessment Plan

Program Management
Program management is the process of ensuring that managed care plan(s) meet the standards set by the state for quality management and improvement and that these standards result in the achievement of desired outcomes. The goals of program management are not only to ensure that appropriate care is delivered to enrolled beneficiaries, but also to continuously improve the delivery system. Programs that serve SSI eligibles or that integrate long-term care physical and behavioral health services are relatively new. Few generally accepted performance standards exist for this population. This increases the importance of focusing program management on making sure that the proposed standards actually result in the desired outcomes and also contribute to ongoing system improvement.

Programmatic Goals:

1. Health: The MCO and its providers will deliver the best possible health care, including mental health and substance abuse care.

2. Access and Comprehensiveness: The MCO will provide timely access to a full range of services, particularly services for people with disabilities and specialized care related to mental health services.

3. Continuity and Coordination of Care: The MCO will coordinate, organize, and facilitate care in order to deliver services in an effective and efficient manner. Particular attention will be given to assure continuity of care across settings and providers.

4. Consumer Rights and Input: The MCO will be responsive to member preferences, goals and interests.

5. Consumer Satisfaction: The MCO will seek to assure that its members are satisfied with the manner in which services are delivered and with the outcomes of those services.

Quality Strategy
When planning for using data in program management, it is important to consider a variety of factors including available resources, the relative importance of program goals, the availability of measures that address these goals, and the time it takes for actions to create measurable changes in performance.

Data and Information Sources:

1. Aggregate Utilization Data
2. Claims/Encounter Data (which provider delivered which service to an individual, on what date, to treat what condition)
3. Care Coordination Data (initial assessment, care plan)
4. Quality Indicators /Outcomes[MEU]
5. Satisfaction Surveys
    a. Consumer surveys (CAHPS, MHSIP)
    b. Provider surveys
6. Grievances and Appeals
7. EQRO Reviews
   Purpose: To ensure that State Medicaid agencies or their contractor can determine, in a manner consistent with standard industry practices, the extent to which MCOs comply with Federal quality standards.
    a. Administrative Reviews
        - Availability of Services
        - Establishment of Provider Networks
        - Continuity & Coordination of Care

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- Coverage & Authorization of Services
- Grievance Systems
- Enrollee Information
- Enrollee Rights
- Confidentiality
- Enrollment and Disenrollment
- Use of Practice Guidelines
- Quality Assurance Plan, Program and Coordination
- Subcontractual Relationships and Delegation
- Health Information Systems

b. Validating Performance Measures

c. Performance Improvement Studies – these projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustainable over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction

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